Nursing Staffs' Perceptions of a Generic Service Manager Position

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Abstract

The recent reengineering within the health care industry has challenged many assumptions regarding traditional structures and roles. Within a product-line management structure, the traditional viewpoint that those who manage patient care areas must have a nursing background, is an example of one such assumption being challenged. The nursing profession is often seen as the greatest obstacle to the implementation of a product-line management structure and generic manager positions (does not require a nursing background), due to the perceived loss of professional identity.

This qualitative study focused on how nursing staff within a chronic care and rehabilitation facility perceived a generic service manager position. Focus groups were conducted in three phases, over a 14 month period of time. The data collected from the focus groups were then coded according to common themes. Each phase was analyzed independently, with the study concluding with an analysis and interpretation of the collective results.

The results of this study revealed a significant shift in how the nursing staff perceived their professional identity and accountability in light of the implementation of the generic Service Manager position. Initial reactions of personal and professional vulnerability and resentment were seen to transform into an increased ability to explicitly articulate the role of nursing. Changes in behavior that were described included: increased consultation and collaboration with other

care providers, increased accountability for professional activities, and increased involvement in strategic activities within the organization.

The results of this study are relevant to all nurses regardless of the organizational structure they may be in. Nursing leaders within the health care and educational communities will also find the results of interest as they attempt to prepare the nursing profession for the present and future challenges being faced by the health care industry.

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CHAPTER ONE: INTRODUCTION TO THE PROBLEM

Today's health care industry is being faced with many challenges that were once thought to be restricted to the manufacturing industry. Competition, decreasing revenues and limited resources are the driving forces for many health care organizations to reexamine how they deliver services. In many cases, a complete reengineering of the organization is undertaken in an attempt to deliver services in the most efficient and effective manner possible. Reengineering within health care can take many forms, ranging from the complex merger of facilities to the implementation of service delivery models. Within an environment of re-engineering, all aspects of the organization are examined and reevaluated.

One example of reengineering in health care is the implementation of a product-line or program management model. Within a program management model, the traditional departmental structure is replaced with a program structure, the aim of which is to be provide a range of services to a group of patients who have common needs. With the implementation of program management, division of labor and traditional roles are reevaluated in light of the revised organizational goals. As a result of this, many professional disciplines are now reporting to a manager that may not be of a similar clinical background. This alternative reporting structure challenges professionals' assumptions regarding traditional roles and accountability.

This study will examine the perceptions of nursing professionals within a chronic care and rehabilitation health care facility regarding a generic service manager position (requires a clinical background, but not restricted to nursing). Of particular interest will be the nurses' perceptions regarding their role and professional accountability within this structure.

The background which led to this study, as well as the particular research questions and importance of the study will be presented in Chapter 1. Chapter 2 examines the relevant literature, beginning with a historical perspective of the division of labor and theories of bureaucracy. Current trends in organizational structures that support a generic manager position will be presented. Finally, the relevant literature concerning role theory and transformative learning theory as it applies to this study will also be included. Chapter 3 presents the research methodology that will be utilized for this study, results of the study will be presented in Chapter 4 followed by a discussion of the findings in Chapter 5.

Background

Most organizations, no matter what business they are in, can trace their work styles and organizational structure back to the principles of the division of labor that Adam Smith first described in 1776 (Hammer & Champy, 1993). This division of labor was based on a specialization of tasks or skills that continues to be the foundation on which many organizations are based. The larger the organization, the more specialized the tasks, therefore the greater need for specialized workers.

Max Weber described a division of labor for the modern society that consists of rationalization of work through the bureaucratic form of administration (Krause, 1982). The most common form of action taken here is that toward a specific goal. When applied to health care facilities and the professional health care providers that make up the workforce, conflicts often develop when the goals of the organization conflict with the goals of the professional disciplines employed to conduct the work of the organization. Professionalism is defined by the degree of control that an occupation has over aspects of work (Krause, 1982). Organizational constraints on a professional group's power and control affect the degree of professional autonomy in the workplace.

Although the need for and benefits of the professionalization of workers is a commonly espoused theory, many current structures actually facilitate the deprofessionalization of workers. Deprofessionalization occurs when a profession looses its unique qualities, expectation of work autonomy and authority over the client (Krause, 1982). Deprofessionalization can occur to a profession as a whole or within the profession, as organizational structures create hierarchies within individual disciplines. This can be seen in nursing, as the role of the nurse manager expanded over time, to meet the changing needs of the organization. As the manager's role increased, the role of the clinical practitioner decreased. This resulted in a highly professionalized nursing management staff and an equally highly vocationalized clinical nursing staff (Porter-O'Grady, 1992). As a result of

this bureaucracy within nursing, many clinical nurses are unable to articulate what their role is within the big picture of the organization, as well as the overall health care delivery system. Decisions regarding clinical practice are made by the managers not the clinical nurses, further limiting the clinicians' autonomy and accountability regarding their practice. A self-fulling prophecy is created when nursing staff delegate decision making to the nurse manager, becoming passive recipients to change, and hence are unable to participate in future decisions due to lack of appropriate skills and information.

Many recent changes in organizational structures are bringing the issue of deprofessionalization to the forefront. As more organizations implement models such as program management, many leaders within the professional community, particularly nursing, argue that this will undermine the profession. Nursing is often identified as a major opponent to program management due to the perceived loss of authority as departments are eliminated (Alexander & Robison, 1991).

Specific to this research study is the organizational restructuring (implementation of program management) that has occurred at West Park Hospital in Toronto, Ontario and the effect it may have on the professional nursing staff.

West Park Hospital is a chronic care and rehabilitation facility that employs a wide variety of professional disciplines, the largest of which is nursing. Prior to 1991, West Park Hospital operated under a traditional, departmental structure. Departments were reflective of various specialty areas which included clinical as

well as support areas (see Figure 1). In an attempt to increase the effectiveness of the organization, the hospital implemented Program Management in April, 1992. As a result of this, many functional departments were eliminated (Nursing Department included) as were the Director positions that were associated with these areas. Professional staff are now employed by the specific Programs (as opposed to the Department), and many disciplines find themselves reporting to managers not of their clinical background. Although the Department of Nursing and the Director of Nursing positions had been eliminated, the Nursing Unit Manager position remained in place (see Figure 2). So for the nursing staff, their day-to-day reporting relationships did not change. This would prove to be a temporary situation.

In July, 1994, West Park Hospital further refined the Program Management structure. The model of service delivery was further refined and decentralized at the point of service. It was with this phase of restructuring that the position of the Nursing Unit Manager was eliminated and the position of the Service Manger was created (see Figure 3). The candidates for the Service Manager positions are not required to have a nursing background (and in one case, no clinical background is required). The issue of non-nurses managing "nursing units" has been a subject for debate within the internal and external nursing community, raising many questions and challenging assumptions.

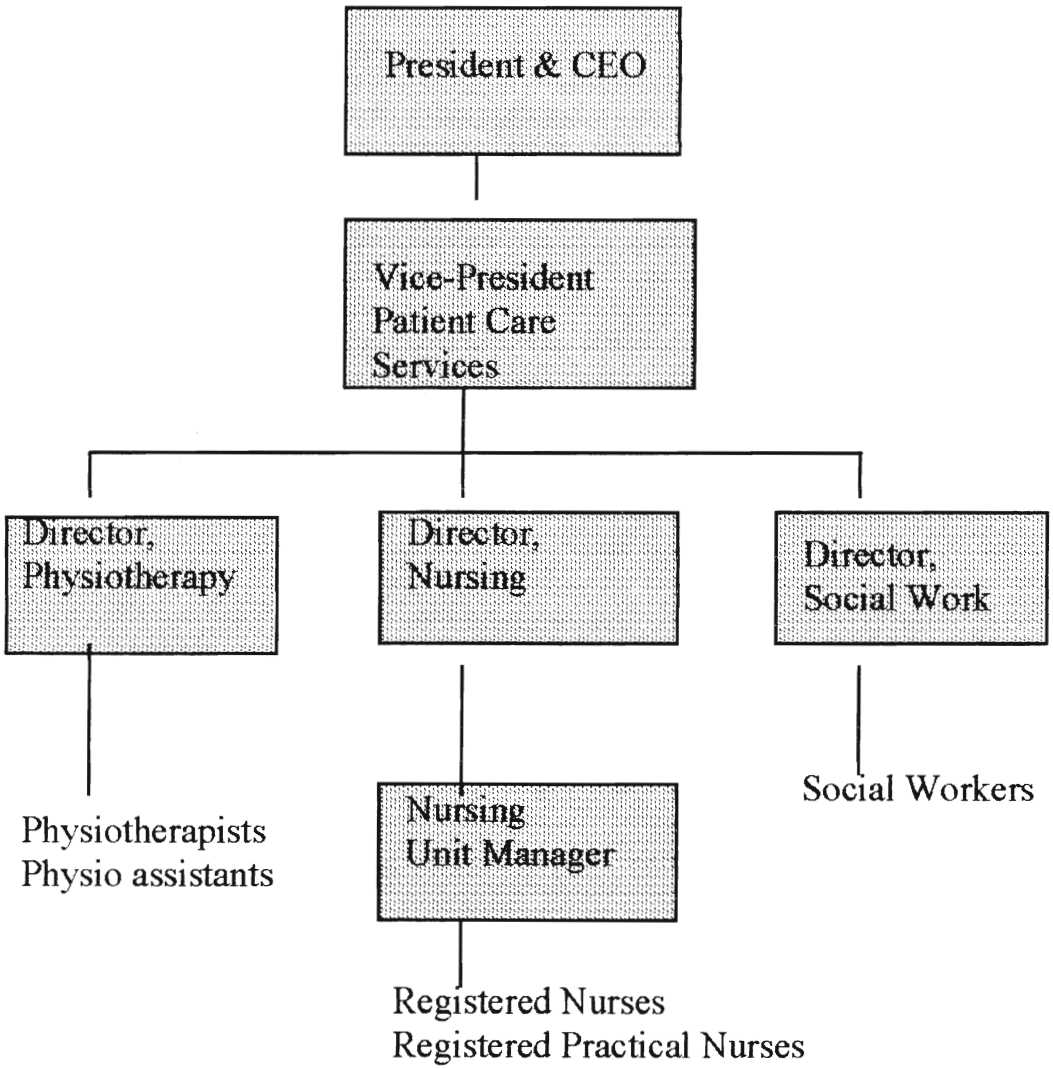

Figure 1: West Park Hospital original departmental structure.

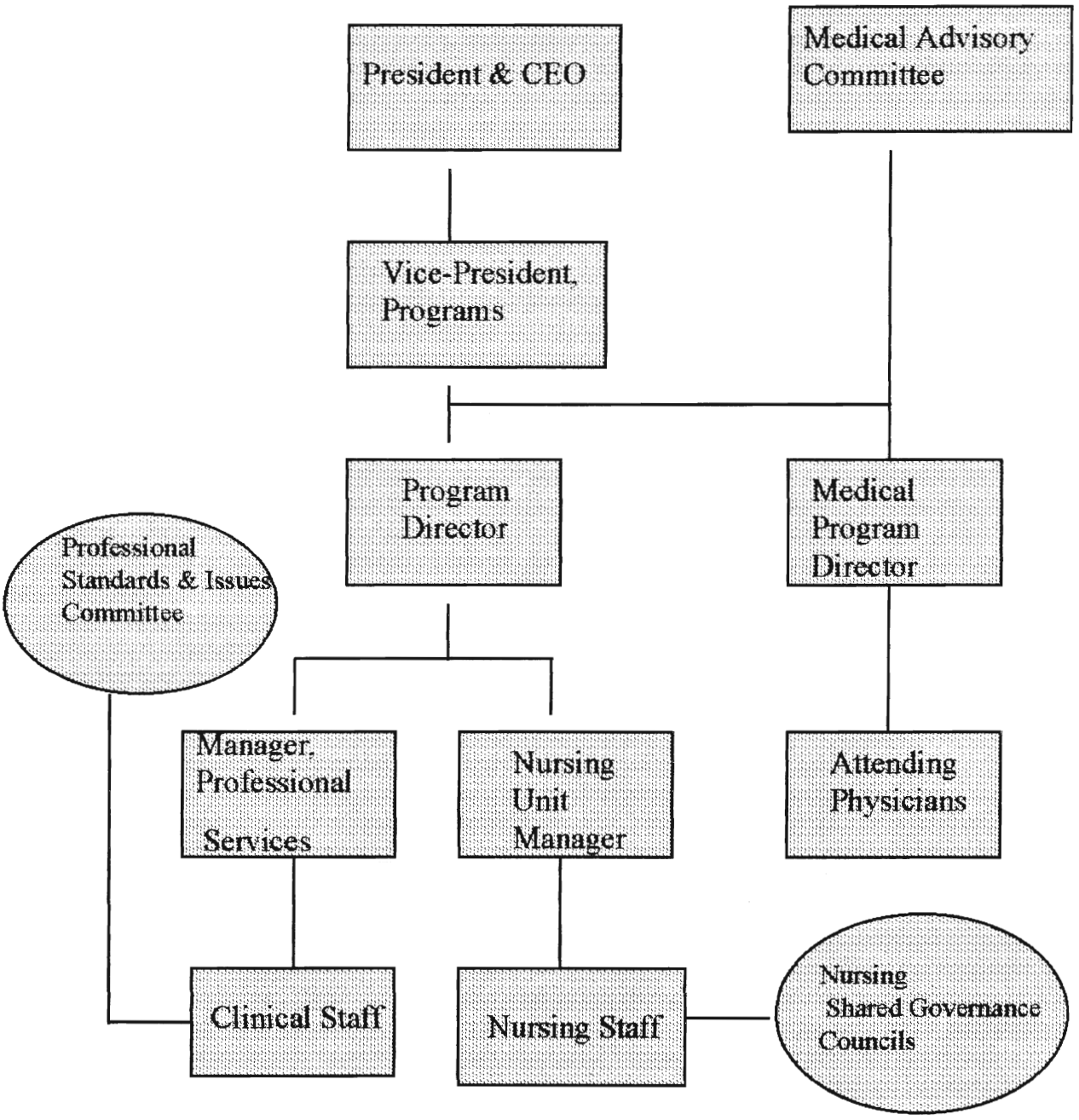

Figure 2: West Park Hospital program management structure (1992).

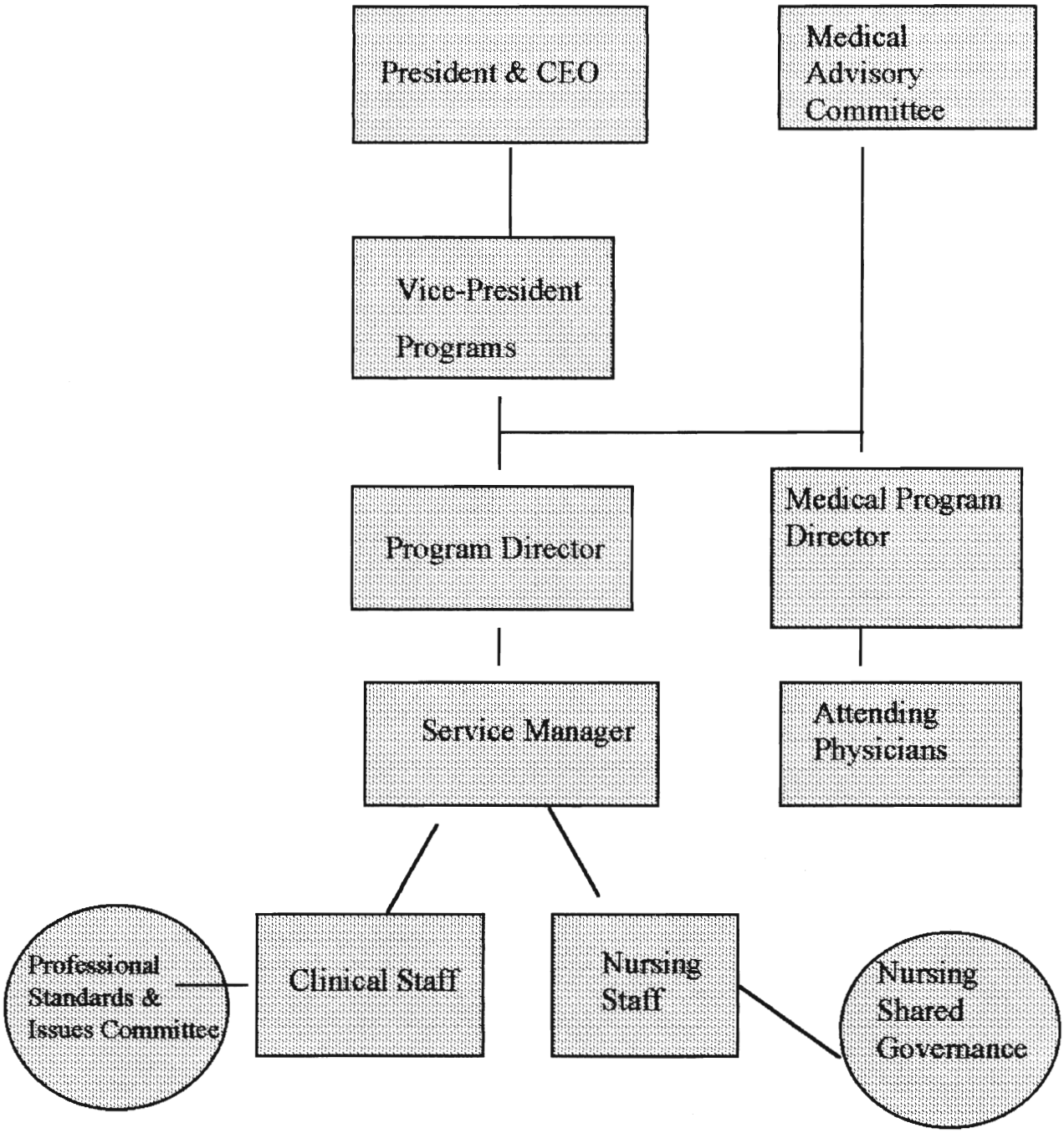

Figure 3. West Park Hospital current program management structure.

Ironically, nursing leadership has placed itself in an awkward position by shifting some basic principles from care and service to those of efficiency and management. Once this occurred, it became a relevant question as to whether business managers were not better suited for the activity of managing the patient areas due to the lack of management content in nursing curriculum (Krause, 1982).

The Service Manger position within this organizational structure is actually forcing the nursing professionals at West Park Hospital to reexamine their role and accountability with regard to their individual and collective professional practice. This event has triggered exciting dialogue in some and paralysis in others. Colleagues in the internal and external nursing community are divided as to the effect that this may have on the nursing profession as a whole.

Many view this as a journey into discovery. It has been said that today's nurses are transformational people, neither here nor there, but rather perennially on a journey (Porter-O'Grady 1992). It is hoped that this study will provide insight into the journey that these professionals have embarked upon.

Research Purpose and Questions

The purpose of this study is to determine how professional nurses perceive the generic Service Manager position as it relates to their professional identity. Of particular interest will be the nurses' perceptions regarding their own professional autonomy and accountability in light of this new reporting structure, if these

perceptions change over time, and to note if there are any changes in behavior as a result of any revised or new perspectives.

Scope of the Study

This study will focus specifically on how nursing staff perceive the Service Manager position as it relates to their professional sense of self. Although there are many additional issues in the health care system that may foster internal reflection, the focus here will be confined to the position of the generic Service Manager and how nursing staff perceive their role in within this structure.

Importance of the Study

The notion that patient care areas must be managed by nurses has traditionally been viewed as somewhat of a "sacred cow." Yet, when nurses are asked to articulate the basis for this argument, the individual cannot explicitly explain something that appears to be implicit to the collective group. The results of this study will be of particular interest to all nurses regardless of the organizational structure they may be in.

The health care system is in a state of constant change. There is no real model remaining that can be considered adequate for the future (Porter-O'Grady, 1992). Therefore, nurses need to be able to adapt to an ever-changing environment. In order to do this, perceptions and assumptions must be critically reviewed to determine if they remain valid in light of the current reality. It is hoped that the dialogue that occurs as a part of this study will assist to raise implicit assumptions to

a conscious level. This will not only be of benefit to the individual, but by sharing the results, the collective may also benefit from the experience.

CHAPTER TWO: REVIEW OF RELATED LITERATURE

In order to develop a comprehensive understanding of the impact managerial positions may have on staff, several areas need to be investigated. First, a review of the historical trends and theories regarding the division of labor and bureaucracy that are the foundation for organizational structures will be presented. This will be followed by a review of relevant theories of organizational structure and management theory. General theories as they apply to organizations as a whole as well as theories specific to the profession of nursing will be examined. Finally, the literature regarding role theory and transformative learning theory and their applications to the subject will be included.

Historical Perspectives: Division of Labor and Management Theory

Today, most managers and administrators would claim that the division of labor and related specialization of skills and tasks are necessary due to the complexity of modern organizations (Greenbaum, 1979). Yet, most organizational structures, no matter how sophisticated they may appear to be, can trace their administrative style back to the principles of the division of labor that Adam Smith first described in 1776 (Hammer & Champy, 1993). Smith based his principle of the division of labor on the observation that, if specialized workers were given a specified task, production would be increased dramatically. With this in mind, all employees in every type of organization can be described as participants involved in a 200 year

old experiment that continues to simultaneously validate and nullify many theories regarding the division of labor and bureaucracy.

Karl Marx viewed the division of labor as an entity that is forced upon the individual and on society as a whole. He viewed the division of labor into specialized skills as separating the activities of the head from the activities of the hand and that this would only result in the diminishment of the individual (Greenbaum, 1979). The structure that the organization creates to meet the corporate needs (political and economic) are often in conflict with the value-based needs of the individual. Although Marx was not opposed to structures that provided guidelines and predictability, the concern was with the purpose for these guidelines and strategies. The more removed the workers are from the complete process, the more dependent they will be on management for the coordination of efforts and further direction.

Extensive specialization and division of labor requires that at some point all of these separate pieces must be pulled together in some organized manner. This establishes the framework for yet another form of division of labor. Max Weber describes the modern division of labor as being the rationalization of work through the bureaucratic form of administration (Krause, 1982). Bureaucracy establishes hierarchy within an organization. Degrees of decision making are determined by established protocols and placement within the organization. Weber maintains that once individuals become a part of the bureaucracy, they lose their ability to choose,

as a condition of employment. Of particular relevance is the relationship of rationality and the professions. Weber viewed professions as aiding the bureaucratic structure due to their inherent specialization within their profession. Yet, conflict may develop as the goal-based rationality of the organization may conflict with the value-based goals of the profession. It is the degree of autonomy and control over work that determines the extent of a bureaucracy. Some people can have control or input into the corporate goals or simply have control over their work (professional practice), while others control the workplace itself. Professionalism can be defined in terms of the degree of control that an occupation has over aspects of its work (such as training and research). When coupled with the division of labor that occurs in a bureaucracy, many occupations are now being faced with the concept of deprofessionalization. Deprofessionalization occurs when the professions lose their unique identity, knowledge base, authority over the client, and public recognition. Public status is highly regarded as it correlated with degree of autonomy -- the higher the status in the community, the greater degree of autonomy in the workplace (Krause, 1982).

Deprofessionalization specific to the nursing profession can be traced to the mid-1930s. In an attempt to modernize the hospital systems, the American Nurse Association (in a joint project with the American Hospital Association), developed a hospital hierarchy based on Taylor's principles of work division. The work of health care was divided into the smallest components, allowing for the introduction

of unskilled or semiskilled workers (Krause, 1982). The task orientation to the provision of care was established. Professions, including nursing, began to protect their "territory" by specializing skills to ensure job security. Although this may have caused conflict or concern within the nursing community, historically nursing has never had the solidarity to confront administration.

When nursing leadership established rationalization of service as a goal, the guiding principles changed from those of provision of care to that of efficiency and management. Ironically, this change prompted the relevant question as to who is better prepared to manage patient care areas? Based on rationality, business managers would be better suited due to the lack of business content in nursing curriculum. In an effort to provide better overall service, the nursing profession actually placed itself in a position of functional redundancy. This event is not limited to the nursing profession; changes in the division of labor can eliminate any occupation. It is interesting to note that the more professions specialize in an attempt to secure their place in the organization, the more limited they become in responding to global changes (this concept will be addressed in more detail later).

Management Theory

Although the concept of management as a science has often been suggested, there is no firm set of principles or consistent body of knowledge to warrant such a claim. It is more appropriate to describe management in terms of concepts that may range from very theoretical in nature to very concise and practical.

Management theory can best be described as a developing set of definitions and strategies (Krause, 1982). The key concept in this statement is "developing." In terms of management structures or models, considering the ever-changing environment in which we live and work in, all models should be considered works in progress.

Early management theories include Theory X and Theory Y. These theories were not based on the division of labor, but focused more on the behavior or motivation of the laborers. Theory X sees workers as constantly fighting for their own goals, even at the expense of the organization. In response to this the organization is required to use coercion and authority in order to ensure that corporate goals are achieved. According to Theory Y, workers are basically good people that can be motivated, but motivation is to be controlled by management (Greenbaum, 1979). These theories rest on the premise that successful management depends on the ability to control, not only the working environment, but human behavior as well.

Karl Marx's concerns regarding the separation of the activities of the head from the activities of the hand were realized with the principles included in Taylor's Scientific Management. Taylor suggested that increased production could be accomplished by compelling workers to intensify their work. Criteria for pace of work and definition of tasks were seen to be the responsibility of managers. Division of labor occurred as elements of work were broken down to those that

required thought (knowledge) and those that required action only. Taylor suggested that management could regain control by removing knowledge and certain skills from the worker's arena and place it within the realm of management. Although increases in productivity were realized in some organizations, the problems that were created with labor eventually caused "Taylorism" to be outlawed from government installations in the United States by the early 1900s (Greenbaum, 1979).

As the workforce increased dramatically, management attempted to control workers by including the working environment as a variable. This involved getting the workers to adjust to the environment, or actually adjusting the environment to meet the needs of the worker.

Studies in this area suggested to management, that if the workers are happy, production is increased (Greenbaum, 1979) . This opened the door for the emergence of a humanistic approach to management and organizational structure.

Current Management Theories

Although many organizational structures continue to be based on principles of the division of labor, this practice is considered obsolete in today's world of competition and change (Hammer & Champy, 1993). Within the health care industry it is also evident that the traditional departmental approach to the specialization of services is no longer adequate. When the delivery of care is structured around the specialized functions of the health care providers as opposed

to the complete service required by the customer, the desired outcomes become difficult to achieve and measure. As organizations become more complex, functional structures become less efficient, in part because they encourage vertical communication within single professional groups, instead of horizontal communication between diverse professional groups (Baker, 1993). Companies who wish to survive are now focusing services based on the needs of the customer, not for the convience of the care providers. The desired goals and outcomes of the client (customer) are the primary focus and the critical evaluation of outcomes are paramount to the success of the organization. All key players (management and workers) need to be involved if process analysis is to be effective.

Theory Z picks up where Theories X and Y left off. The Theory Z approach to management suggests that if workers are involved in the entire process, that this will lead to increased productivity (Ouchi, 1981). An important component to Theory Z is the element of non-specialized career paths. This is the complete opposite of the principles found in the division of labor. The workers in a Theory Z organization receive training in all aspects of the company business. This emphasis on company-centered skills as opposed to task-centered skills enables workers to see how they contribute to the overall goal of the organization. It also assists in enhancing loyalty to the organization's goals and objectives, not just to the specialty itself. The business of health care requires specialization to a certain degree in order to be effective, but the important component in Theory Z is the involvement

of workers in processes that enable them to relate their contribution to the overall big picture.

The underlying principles of Theory Z (emphasis on the complete picture, not individual tasks, involvement of staff in decision making, and emphasis on the "company goals") have many applications when considering the current trends in health care reengineering. It is these very principles that are common to the organizational structures that are being implemented. Structures are being created that are patient centered and outcome focused, using an interdisciplinary team approach to provision of health care that facilitates an environment of professional autonomy and accountability. Reengineering extends an approach to dismantle traditional structure in order to make it easier to respond to the needs of the customer. Process reengineering asks that we challenge the basic assumptions about the health care process. These structures differ greatly from the historical approach to health care that was (and still is) deeply rooted in the principles of the specialization of labor and centralized decision making. The challenge for many organizations making this transformation is to be clear on what "the business" of the organization is and who needs to be involved in the decisions that affect the business.

Program Management

Program management, as an organizational structure, is not a new development. It has been used in industry since the 1930s with the first implementation within a

health care facility occurring in 1970 (Baker, 1993). The underlying principles of Program Management (sometimes referred to as product-line management) are consistent with the principles described within Theory Z. Program management focuses on the delivery of services that are focused around a client population with similar needs. For example, the purpose of a Geriatric Program would be to provide a continuum of services specific to the needs of a specific geriatric population. The providers of those services (nurses, variety of therapists) are then identified and located in proximity to the client. Instead of being employed by the professional department, the health care provider would be employed by the program and would be located at the client care unit. Horizontal communication between professionals is facilitated through the development of the team approach to provision of health care services. The entire interdisciplinary team, in consultation with the client, is involved in determining the plan of care for the individual client. Within a program management structure, decisions are made as a collective group of health professionals focused on a common goal, instead of individual disciplines acting in isolation. It is commonly believed that those who are closest to the issue and will be most affected by the outcomes are best suited to make the decision. This decentralization of the decision-making process promotes the involvement of all key players in decisions whose outcomes are identified as having potential or actual impact on them. Individuals or groups that are actively involved in the decision-making process are more apt to invest in the process to

ensure that the desired outcomes (of the professional and the organization) are achieved. This in turn may help to avoid a common organizational learning disability: "I am my position." An organizational afflicted with this disability will contain workers who can describe their job, but not their role in the overall corporate goals (Senge, 1990).

Although the decentralized approach to decision making is seen as a major advantage to program management, there are several issues that are specific to professional groups working within the structure. A major issue for many professionals is the fear of losing their professional identity within the larger program structure (Baker, 1993). With the elimination of the discipline specific departments, professionals fear that their unique identity will be lost within the collective view of the interdisciplinary team. The loss of the discipline-specific department heads and the function they played as advocates for the discipline, leaves the professionals feeling vulnerable to decisions made by those outside their discipline that may affect their practice. Concerns that professional standards will diminish are also frequently expressed in light of the decreased disciplinary-specific focus. The emergence of "generic" managers of various professional backgrounds accountable for diverse groups of professional health care providers is also challenging the assumption that health care professionals can only be effectively managed by "one of their own." A specific concern to nursing, is the business

orientation of program management in health care being viewed by some as detracting from the human caring aspects of nursing.

Shared Governance

When considering these concerns as they apply to health care professionals, Shared Governance is viewed as a means to address the role ambiguity that may occur within a program management structure. Shared Governance is a collaborative management style that recognizes the interdependency of managers and clinicians. Within a Shared Governance model, distinct areas of accountability are identified. The clinicians are seen as having final authority over clinical practice issues whereas managers have final authority over operational and management issues (Porter-O'Grady, 1992). The legitimate locus of control for professional practice issues is viewed as residing with the professionals. This is what distinguishes Shared Governance from participatory management. Participatory management encourages collaboration, but maintains that the ultimate authority for decision making rests with management.

Fundamental to Shared Governance is the concept of professional accountability. Accountability within a professional context can be defined as the exercise of activities that are inherent to a role, that cannot and are not legitimately controlled outside the role and for which the locus of control emanates from within the role (Porter-O'Grady, 1992). Accountability differs from responsibility in that responsibility reflects an assigned role while accountability reflects an ascribed role.

The five areas of professional accountability include: practice, quality, competency, research and management of resources. Practice, quality and competency are the accountabilities that are viewed as being exclusive to the clinicians. Management is seen as having no legitimate locus of control within these areas. This is particularly relevant in light of changing reporting structures, where the manager may not be of a similar clinical background. The area of research is seen to have a shared accountability between the clinicians and the manager. The clinicians are seen as being accountable for conducting activities that validate current knowledge and create new knowledge, but it is within the realm of the manager to provide the resources necessary to support these research activities, hence the shared accountability in this area. The role of management in a Shared Governance model is to ensure that the working environment is conducive (adequate resources: financial, material, human, and support) so that the clinicians can practice their profession to the best of their ability (Porter-O'Grady, 1992). Shared Governance for nursing facilitates the broadening of professional perspectives by emphasizing the role of nursing in the overall organizational picture beyond that of the skills that are required for the job.

Transformative Learning

Transformative learning is "the process of learning through critical self-reflection, which results in reformulation of a meaning perspective to allow a more inclusive, discriminating, and integrative understanding of one's experience.

Learning includes action on these insights" (Mezirow, 1991, p.xv). This theory of adult learning is of particular significance when considering organizational reengineering and the challenging of traditional roles and accountabilities.

As learners, adults are unique from children in that adults have developed a way of seeing the world that is based on past experiences, knowledge, and values. These meaning perspectives provide a structure or familiar framework which adults use as a means of dealing with future experiences. George Kelly described man as a scientist who is forever striving to understand and control his personal world (Kelly, 1955). Mezirow drew on Kelly's Personal Construct Theory when describing a process that enables the person to order and understand his world. The meaning perspectives described within the context of tranformative learning theory provide a similar function. These meaning perspectives are those assumptions relating to knowledge (epistemic), social norms (sociolinguistic), or self-concept (psychological). Distortions in any of these areas can interfere with the adult's ability to perceive and therefore act within or to a given situation. Assumptions may be considered barriers when they cause the learner to resist new initiatives and limit personal or professional development.

Therefore it is vital for these meaning perspectives and assumptions to be raised to a level of conscious awareness of the learner. For a learner to be truly empowered, distorted assumptions that may act as a constraint to learning must be reviewed in light of the current reality, and revised as necessary.

Reflective learning occurs when these well-established meaning perspectives are brought to a level of consciousness and reexamined as to their validity in the current reality. Transformative learning describes this process in terms of reflection and action.

Mezirow (1991) describes the phases of transformative learning as being initiated by a disorienting dilemma (or some sort of trigger event), that causes an examination of personal assumptions (reflection), determining if the assumptions are valid, exploring alternatives, and then taking action as required.

These trigger events may be as subtle as contradictory information (epistemic meaning perspective) or a significant event such as organizational reengineering which results in changing roles and responsibilities (sociolinguist and psychological meaning perspectives). Whatever domain is challenged, the important result is that reflection occurs and assumptions are questioned and possibly revised.

The process of challenging assumptions has been described as being comprised of three parts (Mezirow, 1991). First, the learner must be aware of the assumptions. Once the assumptions are made explicit, the source of the assumption is considered, as well as any consequences of holding the particular assumption. Lastly, the assumption is questioned for its validity in light of the current context. If the assumption is revised, then a transformation of that meaning perspective is said to have occurred. This process can also be described in terms of content, process and premise reflection (Cranton, 1994). In content reflection, the content (the

"what") of the problem is examined. Process reflection concentrates on the strategies used for addressing the problem (the "how"), while premise reflection is concerned with underlying factors (the "whys") of the problem itself. It is premise reflection that leads the individual towards transformative learning. The questioning of the "whys" will either enhance or constrain the ability of the individuals to address the various "disorienting dilemmas" in their world.

Considering the ever-changing organizational environment today, individuals are constantly being faced with "triggering events" and "disorienting dilemmas." Effective reflection skills are becoming essential in today's dynamic culture.

There are several ways in which reflection can be stimulated. For the purposes of this research study the use of critical questioning skills will be utilized to facilitate transformative learning.

Critical questioning is a specific form of questioning utilized in order to foster reflection, not elicit information (Cranton, 1994). Brookfield describes critical questioning as one of the most effective means by which assumptions can be externalized. Critical questioning is a valuable resource to have in that it can be applied to questions regarding content (the what), processes (the how), and the actual question itself (the why). It can occur through dialogue with another or internally as part of self-reflective process. A sense of disequilibrium (a triggering event) may occur as a result of critical questioning, so care should be taken to ensure that adequate supports are available for the learner. It is not only essential

that the learner be supported during this process, but it is equally important that the learner have supports in place to assist with the implementation of any changes in behavior that are associated with a transformative experience.

In terms of organizational learning, the concepts and principles associated with transformative learning theory are quite applicable. Organizations that wish to not only succeed, but excel in the future need to discover how to tap into people's commitment and capacity to learn. Organizational reengineering is an example of one such activity that requires great commitment and capacity to learn at all levels of the organization. Successful reengineering requires that we challenge our basic assumptions, existing rules and principles (Carmicheal, 1994). Bergman (1994) describes reengineering in terms of starting over with a clean sheet of paper and rejecting the conventional wisdom and assumptions of the past.

It is because of these requirements, that many reengineering projects fail. They conflict with deeply held internal images of how the world works, limiting us to the familiar ways of thinking and acting (Senge, 1990). These internal images, or mental models, need to be managed if organizations are to succeed. The management of mental models includes the surfacing, testing, and improving these internal images. Reflection skills are key to the process of managing mental models. They concentrate on slowing down the thinking processes so we can become more aware of how we form our mental models and the ways they

influence our actions. These activities are seen as paramount to the overall success of any organization.

Role Theory

Role theory is concerned with the study of various processes that produce and explain behaviors. Role theory has also been described in terms of a field of study whose domain is the study of real-life behavior as it is displayed in on going social situations (Biddle & Thomas, 1966). Elements often examined within this domain include phases of socialization, interdependence among individuals, characteristics of social positions, and the specialization and division of labor. Role theory attempts to describe behaviors in terms of values, mores, norms and how they form the basis for the development of roles, social structures and social organizations. Roles, and the relationships they create, can be described as the thread from which the fabric of social organization is woven. They are vital to the system structure which allows for predictability in human behavior (Bertrand, 1972).

The norm represents the smallest unit of the social structure. Norms are clustered together to form roles, which in turn are used to define positions, structures and complex organizations. At the very core of the normative structure is the mos. A mos is a commonly accepted rule of conduct that is strictly enforced. Mores (plural of mos) are derived from an unknown origin, unquestioned, and unchanging. They are reflective of the perceived importance of the behavior on the actual survival of the group. If the mores are considered to be morally right, then

to question them can be considered to be morally wrong (Davis, 1966). It is only when these mores are questioned that people will reflect upon them. Because of its perceived importance to the group, there is a great unwillingness to see a mos questioned or "violated."

Considering the mos as the basic structure of the norm, it is relevant that a norm would be defined as the required or acceptable behavior for a given situation that provides a standard for behaving as well as for judging behavior (Bertrand, 1972). Norms are often described in terms of the characteristics they possess. Absolute norms are those norms which are known and supported by everyone, apply to everyone in all situations, and which are rigorously enforced as compared to conditional norms which have limited application and are only enforced sporadically. The intensity dimension of a norm refers to the perceived importance of the norm and the severity of sanctions applied should the norm be violated or challenged (Bertrand, 1972). A norm is considered to be crystallized within a group when the members' idea of what is appropriate or inappropriate is consistent throughout the group. The high crystallization of norms within a group has been positively related to organizational effectiveness (Jackson, 1966).

As described previously, norms are clustered together to form a role. The term role can be defined as the expected and actual behaviors associated with a position. Therefore, the concept of role applies not to individual personalities or persons, but to positions within a structural system that includes people, positions and tasks

(Oeser & Harary, 1966). Although the concepts of role and position (or status) are quite inseparable, it is important to note the relationship between the two. A position or status is the collection of rights and duties and is distinct from the person who may occupy it. An individual is assigned to a position and is seen as performing the role when the rights and duties are acted upon. Role positions have certain expectations associated with them, but these expectations are determined by the needs of the social structure in which they are imbedded. Roles are not created or discarded as easily as norms because of their greater significance to the larger social structure.

Positions within a structure are described as being comprised of role sets. A role set refers to a complement of specialization that is characteristic of the position. The concept of role set and division of labor are similar in that a description of all the role sets for each person within a system would be reflective of the division of labor for these persons. The concepts of specialization and division of labor are related yet different in that specialization refers to the amount and number of different behaviors engaged by a particular person while the division of labor has reference to the particular complement of specialization (Biddle & Thomas, 1966).

As previously mentioned in the review of the historical perspective on the division of labor and management theory, it is this specialization and division of labor that most organizations and institutions have used as the foundation on which to build their structures. Within role theory, an institution can be described as a set

of mores and laws built around one or more functions (Davis, 1966). Complex organizations are a type of social system that is comprised of two or more groups with specialized functions that are dedicated to a particular goal. Hospitals and universities are examples of complex organizations.

As we consider the overall function and importance of mores, roles, and role positions within the context of social organizations, we can begin to understand the barriers that are faced when organizations attempt to transform themselves. The process of organizational transformation, or reengineering, challenges the basic assumptions about the purpose of the organization and how that organization will function. Within this global perspective, traditional role positions are challenged, resulting in the individual's perspective on his or her role also being affected. The effects of reengineering in health care, particularly on nursing professionals, is a good example of how changes within a structure can be seen as challenging the very mores of a particular group.

There has been a great deal of role diffusion in the health care industry, as nursing professionals are being asked to assume tasks, functions and roles that have traditionally been associated outside of their role. Role expansion has occurred as nurses at varying levels adopt and assume tasks that have been previously assigned to other role positions (particularly management positions).

A common example of this would be the concept of decentralized decision making and staff empowerment. Clinicians are requesting that they be involved in

decisions that will affect them, but to be involved in this process will result in less time directly spent providing patient care. The individuals in this type of situation may experience different aspects of role stress. They recognize the importance of being involved in these additional activities, but feel guilty about decreasing time spent with patients. As positions are being redefined, role ambiguity may result from a lack of clarity in role expectations. Role inadequacy may occur when the individual is assigned to a role for which he or she is not adequately prepared. As a result of this type of situation, role frustration occurs when the individual is unable to fulfill the role in the way he would like or others expect him to (Bertrand, 1972).

A major issue for many professionals is the fear of loss of a professional identity in the reorganization process. Norms that were once considered absolute are now questioned, revised or even discarded in light of the current reality. A specific example of this is the assumption that the manager of a nursing unit does not necessarily have to be of the nursing profession. The traditional view of the nurse manager position might be described in terms of an ascribed status. Ascribed statuses are those assigned to individuals without reference to their innate differences or abilities (Davis, 1966). Candidates for nurse manager positions were (and still are) often nursing clinical experts with little or no management background or experience. The foundation for this rationale can be traced back to the concepts of specialization and division of labor already presented.

Organizations are now transforming this position into an achieved status , one earned through the demonstration of some special ability. The debate continues as to the best definition of "special ability."

Summary

The literature reviewed in this section consisted of an historical perspective on the division of labor and management theory, continuing with recent trends in management theory with particular emphasis on the impact that these theories had and will have on the nursing profession. We can see how external structures impacted on the individual's role and ability to participate in decision making. This will be of considerable importance when examining the impact that the generic Service Manager position has on nursing staff.

The implementation of this position may be viewed as a "triggering event" that precedes transformative learning. The strategies presented for facilitating self-reflection (critical questioning) will help to support nursing staff through what may be perceived as a disorienting dilemma by some and an opportunity for personal discovery by others.

CHAPTER THREE: METHODOLOGY

Overview

This chapter will present the research paradigm and specific methods utilized for the study. An overview of the specific research methodology will be presented, including the rationale for the use of the methodology as it applies within the context of this study. This will be followed with a description for the procedures related to: participant selection, data collection and storage, and data analysis .

Research Paradigm

When considering the focus of this study and the questions that are being addressed, a qualitative research approach is viewed to be not only appropriate, but essential if the desired outcomes are to be actualized. Qualitative research is distinguished from quantitative research in that quantitative research is concerned with frequency while qualitative research is concerned with abstract characteristics of events (Kincheloe, 1991). When considering the aspects of social research, qualitative research methodology is best suited to challenge the assumptions that are already present within the social context being examined and appreciate the value of the experiences of the individuals involved. These assumptions, human experiences and individual perspectives are the essential features of qualitative research. Qualitative research is viewed as research that is not done "to" other people, but research done "with" others in relationships of trust and respect (Rothe, 1993).

Not unlike quantitative research, qualitative research is comprised of many orientations. The specific orientation that will be applied to this research study is that of ethnomethodology. Ethnomethodology can be described as the study of knowledge, procedures and reasoning that people use to make sense of the circumstances in which they find themselves in. It attempts to make explicit, the assumptions that people take for granted. The goal of ethnographic research activities is to develop an understanding of the "world" as it is experienced by the "natives" (Deyhle, Hess & LeCompte, 1992). On a larger scale, ethnographic research attempts to gain knowledge about a particular culture, to identify patterns of social interaction and to develop holistic interpretations of societies and social institutions (Kincheloe, 1991).

The purpose of the study is to determine how nursing staff perceive the Service Manager position as it relates to their "world" of traditional roles and professional responsibility. The orientation and philosophy of ethnomethodology is compatible with the purpose of this research study. Ethnographic analysis portrays immediate interaction as the collective activity of individuals in institutionalized relationships who are both reproducing and transforming their own histories and that of the larger society in which they live (Erickson, 1992).

Role of Researcher

Prior to and for the duration of the study, I was employed at West Park Hospital in the position of Organizational and Personal Development Consultant with the

Department of Quality Development and Educational Resources. Although my role within the organization was to provide educational support to all employees, my primary "customers" were the nursing staff-- due to my nursing background, and ability to identify and address their professional needs. There existed a relationship of trust and mutual respect between myself and the nursing staff. They often told me that I was trusted because, in their opinion, I "never forgot what it's like to be a nurse."

In terms of the research study, my role can be described as that of participant observer. It was part of my role within the organization to assess the needs of the nursing staff and determine the best possible ways to address those needs.

With regard to the implementation of the Service Manager position, as a nurse, I was not opposed to the implementation of the Service Manager position. However, I did anticipate that this would indeed prove to be a major trigger event for the nursing staff, and that they would need to be supported as they adjusted to the new structure and reporting relationships.

Selection of Participants

The participants for this study consisted of the professional nursing staff employed at West Park Hospital. Participants were not actually selected (as through a lottery system), but were merely invited to participate in the study. Therefore, the resulting characteristics or demographic profile of the participants were driven by the individuals who chose to participate, not predetermined by the

researcher. All Registered Nurses (RNs) and Registered Practical Nurses (RPNs) employed as staff nurses were eligible to be included in the study. Originally, the study was to be confined to only those nurses who were reporting to a non-nurse Service Manager, but frequent comments from other nurses such as "I wish we didn't have a Service Manager with a nursing background because it would force us to address issues," initiated the expanded study population. Registered Nurses employed in other positions within the hospital (Clinical Practice Consultants and Service Managers) were also invited to participate, but with the request that they participate as "nurses" , not as "managers" or "educators".

All potential participants were informed of the intent of the study and the schedule for the focus groups in the following manner:

1. Presentation to the Nursing Professional Standards and Issues Council in September 1994. This council contains representatives from all nursing areas within the hospital. The representatives were to then forward information back to colleagues on nursing units as part of normal communication structure.
2. Information sheets were sent to all nursing areas informing staff of the intent of the research study, requesting support and participation (emphasizing that participation was purely voluntary) and including the schedule for the focus groups.

3. Reminders were sent via electronic mail to all nursing areas on the morning of a scheduled focus group.

Although all nurses within the organization were notified and invited to participate in the study, the realities of shift work and rotations allowed for only a sample. It is believed that the characteristics of this sample group are reflective of the collective nursing population.

Methods for Data Collection

A longitudinal study design, conducted in three phases over a 14 month period of time, was utilized to determine the perceptions of the nursing staff regarding the Service Manager position and if those perceptions changed over time. The purpose of the longitudinal approach is to monitor the perceptions of the nursing staff over time and to determine what, if any, behavior changes may also occur. A 14 month time frame was examined, beginning in October, 1994 and ending December, 1995. Phase 1 occurred in October, 1994. This coincided with the implementation of the Service Manager position which began on October 24, 1994. Phase 2 of data collection occurred in June, 1994 (approximately 8 months post-implementation of the Service Manager position). Phase 3 took place in December, 1994 (14 months post-implementation of the Service Manager position).

Focus groups were used as the primary method for data collection in the study. The use of focus groups enabled the researcher to utilize the participants' sharing

of experiences and personal interpretation of events, as the "instrument" to generate data. The most desirable feature of focus groups is the interaction between not only the participants and the researcher, but the interaction between the participants themselves. Many researchers feel that the most valuable benefit of focus groups is the dynamics of the discussion that occurs among the participants (Greenbaum, 1993). It is the belief of this researcher that the interactions between participants of these focus groups also yielded many benefits.

Although interactive dialogue is desired during focus groups, it is essential that there be a pre-determined structure and an established question guide that will be followed by the focus group facilitator. Without structure and boundaries, the discussion may not yield the desired results and leave the researcher (and sometimes the participants) feeling frustrated. To ensure that the focus groups were successful as a data collection tool, a semistructured interview format was used. The semistructured interview process incorporates a series of questions that are developed in advance. The questions started out quite divergent in nature and became increasingly more specific to the research topic. Where necessary, probes and open-ended questions were used to elicit more information. Laddering is another technique that assists in probing the participant's innermost feeling about a given issue. Laddering is a questioning technique that enables the researcher to get to the hidden or underlying reasons for why people feel the way that they do about

certain issues (Greenbaum, 1993). This technique is also similar to that of critical questioning (Cranton, 1994).

To facilitate staff participation in the focus groups, an informal telephone survey was conducted to determine the best (and worst times) to schedule the focus groups. Information was collected regarding regular unit-based activities such as staff meetings, interdisciplinary rounds, and patient related activities (admission and discharge days). No less than five focus groups were scheduled for each phase of data collection. All focus groups were conducted from 2:00pm - 3:00pm (the most convenient time for nursing staff) and the locations were varied throughout the facility to make it easier for staff to participate.

To ensure that the data generated from the focus groups were recorded in an accurate and complete manner, the focus groups were audio-taped. This facilitated the analysis of the data over the three phases of the study. The participants were informed that the sessions would be audio-taped prior to the beginning of the focus group. Each participant was requested to sign a consent form indicating that they willingly agreed to participate in the focus group, that they were aware that the sessions would be audio-taped for data collection purposes only, and that they had the right to withdraw from the focus group at any time (see Appendix A). The confidentiality of all participants was ensured by the researcher in order to establish a conducive environment for open, honest dialogue. There was a preexisting relationship of trust and respect between this researcher and the participant

population that also ensured that the needs and concerns of the participants were respected. The audiotapes and signed consents were stored in the home of the researcher to ensure that the confidentiality and security of the participants was maintained.

Data Analysis

Data reduction and analysis occurred on an ongoing basis for the duration of the study. The process of data analysis begins by considering whole events, followed by the analytical decomposing of the data into smaller fragments and finally, recomposing them into a whole and relating this within a social context (Erickson, 1992). The audiotapes of the focus groups were reviewed by the researcher following each focus group, to check for the clarity and quality of information obtained. If required, participants were contacted to verify or validate information contained on the audiotapes. The original tapes were reviewed with a critical "ear" for information relevant to the purpose of the research study. The recorded conversations from the focus groups were then transcribed from the original tape by the researcher. These transcribed segments were applied to a coding system that assisted in determining common themes within the information. A "code" is an abbreviation or symbol used to classify words or sentences taken from transcribed field notes. Coding of qualitative data as a method of data analysis helps to reduce large amounts of data into an ordered pattern, gets the researcher into analyzing the data during the collection, and helps the researcher to build a cognitive map (Miles

& Huberman, 1984). Data analysis occurred in two ways: each phase of data collection was analyzed for common themes specific to that time period and upon completion of the study, the themes from all three phases were analyzed as a collective. As previously mentioned, once the individual pieces of the data were analyzed, the information derived from those pieces was compiled to form a narrative description of the research findings. This is considered the most important part (ethically speaking) of the research process. The researcher has a moral and ethical responsibility to return to the participants and share the results of what was a collaborative effort between researcher and participant-- otherwise, no matter how participatory the research, one can be said to have engaged in little more than social voyeurism (Pitman & Maxwell, 1992). It is the plan of this researcher to return to West Park Hospital in June, 1996, to present the results of the study.

Summary

This study was designed to determine the perceptions of nursing staff regarding a generic Service Manager position with regard to traditional roles and professional accountability. Considering the elements of a qualitative research study, the research methodology was open to review as the study progressed. Any and all methods utilized have been fully documented.

CHAPTER FOUR: RESEARCH FINDINGS, ANALYSIS AND INTERPRETATION

Introduction and Overview

The purpose of this chapter is to present the findings obtained from the research study and interpret their meaning in relationship to the original purpose of the study. The chapter will begin with a summary description of the focus groups and the major themes for each of the three phases of data collection. Each phase of the research study will first be presented individually, with the chapter concluding with an evaluation and interpretation of the collective research results.

Summary Description of Focus Groups

A total of 14 focus groups were conducted during the study, with a total of 47 nurses participating in the focus groups over the course of the study (see Table 1). The nursing participants included Registered Nurses, Registered Practical Nurses, Clinical Practice Consultants, and Service Managers (those with a nursing background). Phase 1 of the study was initiated in November, 1994, with five focus groups conducted and a total of 17 nurses representing 8 out of 16 different nursing areas having participated. Phase 2 of the study was held 8 months later (July, 1995). There were five focus groups conducted with a total of 30 participants representing 9 of 16 nursing areas. Finally, Phase 3 of the study

occurred in December, 1995 with four focus groups conducted. With Phase 3, a total of 16 participants represented 6 of 16 nursing areas.

The data from each phase of the study were examined independently, with a coding system utilized to identify common themes. Although the phases were reviewed independently of each other, there was a consistency to the themes identified in all three phases of the study (see Table 2). In each phase of data reduction and analysis, the themes were placed in an order that was reflective of the intensity in which the participants' comments referred to these areas. The themes that were identified in Phase 1 included: professional identity, education and professional development, and professional accountability. In Phase 2, the themes that were identified consisted of: professional accountability, professional identity, consultation and collaboration, and education and professional development. The themes identified in Phase 3 were consistent with those found in the previous phases. They included: professional accountability, consultation and collaboration, and professional identity.

Phase 1: Research Findings

The data presented here are reflective of the nursing staffs' perceptions of the Service Manager position in the initial stage. Phase 1 occurred in October, 1994 coinciding with the very week that the Service Managers began their new positions (See Table 1). The themes are presented in the order of the intensity in which they were mentioned by the participants.

Table 1

Summary Description of Focus Groups

PHASE	PHASE ONE	PHASE TWO	PHASE THREE
Time Frame	November - December 1994	July - August 1995	December 1995
Total Number of Focus Groups	5	5	4
Total Number & Description of Participants	17 Registered Nurses *, 8 Registered Practical Nurses *includes Service Managers with nursing background	20 Registered Nurses *, 10 Registered Practical Nurses * includes Clinical Practice Consultants and Service Managers with nursing background	10 Registered Nurses, 6 Registered Practical Nurses
Percentage of Nursing Units Represented	8 units (50%)	9 units (60%)	6 units (40%)

Table 2

Summary of themes derived from focus group interviews

PHASE	THEMES (IN ORDER OF FREQUENCY IN DIALOGUE)
Phase One	1. Professional identity
	2. Education and Professional Development
	3. Professional accountability
Phase Two	1. Professional accountability
	2. Professional identity
	3. Consultation and Collaboration
	4. Education and Professional Development
Phase Three	1. Professional accountability
	2. Consultation and Collaboration
	3. Professional identity

Theme # 1: Professional Identity

The theme of professional identity was the prevalent theme that many of the focus group comments revolved around. This theme was interconnected throughout the dialogue generated from the focus groups. The comments expressed by the participants, revolved around how the introduction of this position would affect them, as a distinct group. The general comments that were expressed were consistent within all focus groups and all categories of participants (there was no noted difference between the perceptions of Registered Nurses and Registered Practical Nurses).

The introduction of the Service Manager position was not viewed in a positive manner by the nursing staff. The emotions that were expressed included anger, fear, disappointment and the sense of being insulted. When the participants were asked what they thought of the Service Manager position (specifically that the position did not require a nursing background), a common initial response was "not much!" The anger and disappointment appeared to stem from a perception, that by eliminating the need for the manager to have a nursing background, that somehow "devalued" them as a professional group. One comment in particular reflects this position:

> I would rather have a nurse manager because I think that nurses are special people. I guess it's a really weird thing to say but I really think that we are. But just because we see ourselves as being special, that doesn't mean that others

> will view you that same way. If we were seen as special, I guess that nurses would still be managing nurses -- so I guess we're not that special.

Another participant expressed her sense of disappointment and anger in the following statement : "By having a Respiratory Therapist as a manager, I feel a little bit hurt. If they could find generic managers out there that are good enough to do the job, why couldn't they find nurses to do the job?"

The greatest focus for discussion stemmed from the concern that the service managers (with non-nursing backgrounds), will not "understand nursing as we do." Again, this concern reflects how they view their profession as being quite distinct and special. They questioned the ability of the non-nurse Service Managers to act as their leader:

> How can they relate to what nursing does, nursing is very complex and has a lot of history that makes it difficult for someone who is not a nurse to understand. When we talk about patient care, is she going to know what we are talking about? They also won't understand the nursing profession and won't be able to give us any guidance or provide us with any type of leadership.

Many viewed the Nursing Unit Manager not only as the leader of the unit, but also their professional leader. Many identified the professional support and guidance that they received from the Nurse Manager as having great personal value and consequently felt a void in that area. The void elicits feelings of apprehension and fear. These feelings were expressed by one nurse as

> All of a sudden of [sic] having all these years of having guidance there from the Nursing Unit Manager, and now having that all taken away-- all of a sudden I'm kind of like free falling and I hope that I land on my feet. I really just don't know who I will ask for guidance with regards to patient care issues.

Having a manager that was empathetic to nursing and nursing issues was also expressed as being quite important. Again, the concern that the non-nurse Service Managers will not that have that appreciation for the complexity of the profession was consistently expressed by the participants. One nurse expressed this concern as "I hope that the Service Managers come in and appreciate the nursing staff, looking at the complexity of what nursing is and not looking at it from just the tasks that they see."

Interestingly enough, once they began articulating their concerns about the inability of the Service Managers to understand nursing, the focus of the discussion changed to how the nursing profession has actually contributed to the very situation they find themselves in.

They identified a collective ownership in creating the problem :

> From a nursing perspective, I believe that this has happened because nursing has allowed it to happen. By allowing ourselves to be placed in the background and not being seen as having the expertise that we have. If you were to ask me where nursing sits on the totem pole -- they sit on the bottom. And what really

bugs me about nursing is that we are such a large body of people but yet we seem to have so little control over our profession.

Another area that was identified as contributing to this issue was the traditional hierarchical structure that nursing has been a part of for decades. Nurses reported to nurses, within a health care facility that was structured around the providers of patient care services. If continually surrounded by peers, there is no need to articulate what you do, or why you approach a task in a particular manner.

This has always been a problem for nursing, we've always had that structure, that someone that we didn't have to explain ourselves to. I think that nursing has gotten too comfortable in the fact that we never had to explain ourselves.

They clearly identified that this is a problem that will only be intensified in light of the Service Manager position. Although they feel very strongly that they are a distinct profession that adds value to the delivery of health care, as individuals, they cannot explicitly explain something that is implicit to the collective group. The awareness of this issue can be depicted as:

one of the big problems with this is that nursing can not describe what it is that we do and that leaves us in a very vulnerable position. If you were to go out and ask any of the nurses here right now what does nursing mean to you -- they would have a very hard time coming up with an answer.

There was a great sense of awareness that they now have to prove themselves as a profession.

Along with the challenge of articulating their role, other challenges that were identified included ensuring that the collective nursing perspective would not get lost. The loss of the Nursing Unit Manager also represented the loss of the advocate for Nursing at the corporate level. To presume that role would be assumed by the individual nurses was not considered a reasonable option. The need to have a central focus for nursing was seen as necessary if the professional was to remain proactive;

> I strongly, strongly believe that in situations such as this, what they must have is something along the line of a Chief Nursing Officer - someone that doesn't look at management but at the areas of clinical practice. To cut off that linkage is to truly do a disservice to the entire profession.

In terms of their professional identity and the challenges that they identified, one nurse did view this as a positive situation :

> "I like the idea of the Service Manager position. From what I've seen in the past, having a nurse as a manager really hasn't done much for us as nurses. Now with the Service Manager position, it allows them to step back and it allows us to step forward and take on more ownership of issues."

Theme # 2: Education and Professional Development

Upon review of the data, the comments that were centered around the theme of education and professional development were focused on the areas such as

accountability for learning, skill gaps, and identification of resources. It is within this area that some differences in the perspectives of the nursing staff participants (and the Service Manager participants with nursing backgrounds) were noted.

When addressed with the question "do you see the Service Manager having any role in your professional development?", the overwhelming response from the nursing participants was no. They felt that it should be their own responsibility to ensure that their educational needs are addressed and professional standards are maintained. The comments reflect back to earlier perceptions that Service Managers are not familiar with nursing as a profession; "the Service Manager doesn't know what our standards are, we are responsible to know what our standards are and make sure they are up to par." Some nursing staff identified that this is not a consistent view amongst their colleagues. The mechanisms to ensure standards are maintained, are lacking in terms of the authority to enforce the standards. In the past, the Nursing Unit Manager would identify learning needs and ensure that staff went to inservice training. This is no longer the case and many staff stated that the "nurses don't have anyone telling them to go (to training), so now it's not being done, and with the Service Managers, there are no repercussions for not going." Although all staff participants identified that it was important to encourage colleagues to address training needs, many felt that "I don't feel it's my job to tell someone how to do their job." This was still seen as the domain of the manager, no matter what the professional background.

The Service Manager participants, (those with nursing backgrounds) described the issue of the identification of learning needs in a different manner. They identified that the non-nurse Service Manager "won't be able to alert the nursing staff to some of the actual or potential gaps and things they need to address." There was the perception that nursing staff may not be adequately prepared to assess their own learning needs : " I mean, if you don't know what you need to know -- then how do you know that you don't know it?"

The nursing staff participants did acknowledge that there were resources available to them to help them to address any learning needs. Along with those resources was the recognition that " you have to take the responsibility to utilize them and to take care of your own issues of clinical competency as opposed to waiting for direction from your manager." Resources that were identified included: Shared Governance unit-based councils, the Nursing Professional Standards and Issues Council, guidelines from the College of Nurses of Ontario, and their fellow peers ("you're really going to have to rely on your fellow nurses to help you out"). The Service Manager was identified as being able to supply the resources to assist with educational and professional development; "the role of the Service Manager is to support but not to actually do for us anymore."

Theme # 3: Professional Accountability

This theme focused the idea of the nursing staff being more accountable for patient care. This was viewed as a positive aspect of the change to the Service

Manager position. There was a increased sense of awareness that what was required of them as nurses was changing. One nurse described it in this way:

> There is the recognition that the job of nursing has changed, it's no longer 7:00am - 3:00pm and there is an expectation that if necessary we must stay after 3 o'clock to get things done. All of a sudden it has hit us that we are responsible for issues regarding patient care! Before, the Nursing Unit Manager used to handle those issues -- now they are gone. The Service Manager is there to manage the unit, so as far as patient care issues, nursing is now ultimately responsible."

This additional responsibility was consistently seen as a positive. There were also many comments that reflected a sense of professional liberation: "why do we need a manager for patient care issues? After all that's our thing -- that's what we do"; "it's actually quite good because they aren't around anymore, so now they leave us alone to do our job"; "nurses are professional people -- we should be making our own decisions and doing our own stuff"; and "we're not being babied anymore."

They see themselves as having a lot more control over nursing-related issues. And in some cases, different behaviors are becoming evident: "I've actually noticed something with some of the nursing staff, I don't know if you have, but in some areas nurses are stepping forward and taking responsibility for certain issues."

There was an increased awareness that increased responsibility and accountability were going to rest with them instead of the manager. This was also

seen as being a positive factor: "a lot of responsibility is now really falling on the nurses and in that respect I think its really good for the profession."

Phase 1: Interpretation

When considering the information presented, there is adequate reference to all of the theoretical frameworks that were applied to this study. The nursing professionals at West Park Hospital can be described as having embarked on a journey towards a transformative learning experience. The phases of transformative learning, described by Mezirow (1990) include: a disorienting dilemma or trigger event that causes an examination of assumptions through the process of reflection; the determination if the assumptions are valid, exploration of options, and taking action as required. The initial phases are clearly depicted within Phase 1 of this study.

The implementation of the Service Manager position can be described as a trigger event for the nursing staff. This event has caused them to consider their role within the organization. The experience has clearly been a disorienting one as we recall the nurse who describes herself in a "free fall," hoping that she lands on her feet. The fact that, as nurses, they are unable to articulate their role has caused some concern that it may leave them "vulnerable." There is evidence of a reflective process occurring as the nursing staff refer to how past behaviors have contributed to their present state. The comments that nursing is partly responsible for this and that they need to take more ownership over nursing-related issues,

indicates a questioning of assumptions with the possibility to taking action to change present behaviors.

The argument for describing the Service Manager position as a trigger event is based in the literature regarding the division of labor and the institutionalization of professionals within a bureaucracy. Historically, health care institutions have been structured according to the specialization of skills required and the professionals who possessed those skills. Within the professional groups themselves, a division of labor developed when clinicians assumed a managerial function. The division between the labor of the hand versus the labor of the head created that hierarchy within the professional groups and centralized decision making. Nursing units were managed by nurses -- that's the way the health care industry has been structured for over 100 years. Until recently, one might even consider this arrangement to be a mos within health care. A mos is described as being unchanging, unquestioned, and of unknown origin, and adhered to by all group members (Davis, 1966). This may explain the sometimes extreme emotional response of nurses when faced with the creation of non-nurse manager positions. This challenges them to reflect on their traditional role and envision what may be required of them in the future.

The reengineering that has occurred within health care (particularly West Park Hospital), has challenged those historical ways of structuring facilities, transformed the way services are provided and created new roles for service providers. It will be

of interest to observe how the nursing professionals adapt to the new environment over the next 14 months.

Phase 2: Research Findings

Phase 2 of the study was conducted in July, 1995, eight months post-implementation of the Service Manger position (see Table 1). The focus groups were conducted in the same manner as in Phase 1 with the intent to determine if there was a difference in perspective that had occurred over the past eight months. The same coding system was utilized, with the themes being presented in terms of their prevalence in the data.

Theme # 1 : Professional Accountability

The issue of accountability continued from Phase 1 of the study. The emotional component had decreased and there was more of a objective view of the situation. With regard to accountability, the nursing staff viewed this as a generally positive outcome associated with the Service Manager position. They welcomed the opportunity to be involved in more decision making, thus increasing their professional self- confidence. One nurse described it in this manner :

> We are doing a lot more independent decision making. In the past we would always look at the situation, but then check with the Nursing Unit Manager to see if that is what she would do. Now that that resource is no longer there, we just go ahead and do it and see if it works on our own. Now we just do it!

Another example of the professional "maturing" of the nursing staff is found in this statement:

> I feel that as nurses we are being treated more as professionals as opposed to the maternal aspects of the old head nurse - we don't need to have that old fashioned head nurse chasing you around checking up on what you are doing.

The Registered Nurses identify themselves as now being the most senior nursing position in the hospital (there is no nursing position higher than a Registered Nurse). They enjoy having this role. They feel that "people are looking to the RNs (Registered Nurses) more as the leaders." With this leadership role, the Registered Nurses recognize the need to be more aware of what's going on "because people are coming to me and consulting with me, so I need to be aware so that I can help."

There is also an increasing awareness of the "negative" sides of accountability: that with independent decision making, there are additional pressures. The Registered Nurses in particular were noted to make comments regarding this "negative" side of accountability. One Registered Nurse perceived it this way:

> There is a lot of confusion regarding exactly who is accountable for what. Yet, we understand that nursing can no longer lean back and wait for someone else or shift the accountability to someone else -- the buck stops here! And that make things more stressful because now we have to think of what to do.

Within the area of accountability, the nursing staff are beginning to identify the importance of being involved in additional activities. The additional activities mentioned included: unit council meetings, operational planning, and the budgeting process. Although it can be a challenge to fit these activities into an already hectic day, the nursing staff recognize that "these activities take a lot of time, but it does help us to have a bigger picture of what is going on."

Although the nursing staff feel that they are becoming more accountable, one Service Manager noted that "I still feel that there is a high degree of apathy to get involved and communicate with one another and that apathy just kills me!"

Theme # 2 : Professional Identity

The theme of professional identity took on a different emphasis in Phase 2 than it had in Phase 1 of the research study. The reader may recall that in Phase 1, the nursing staff were feeling very emotional regarding the implementation of the non-nurse Service Manager position. The comments were very much focused on what this was going to do "them." The theme of professional identity in Phase 2 was more reflective of what the nursing staffs' perceptions are regarding the effects of the Service Manager position on patient care. The nursing staff felt that the Service Managers "don't have the same understanding of what the needs of the patient are." There remained some concern, on the part of nurses, that their inability to clearly articulate needs, coupled with the non-nurse managers lack of knowing, will have a negative impact on decisions made: "Is she going to say No to

things because she doesn't understand what we are trying to say?" was often expressed. Because of this concern many nurses identified the need to better articulate their role. This was felt to be very important, not just to them, but to ensure that the patients needs were being met. A nurse put it best by stating,

> we have to work harder to tell the Service Manager about nursing and what we do on a day to day basis. Nursing has to speak up and tell people - hey, this is what we do and this is the value we bring to the patients.

One very interesting perspective came out regarding the relationship of the Service Manager to the "business" of patient care. The nurses articulate that they can understand the rationale for the change in structure, but that they fear that the patients are losing out because the Service Managers are not "a part of the family and don't want to be part of that family." When asked to explain further, the nursing staff talked about their relationship with the patients and their families. Many of the patients have resided at West Park Hospital for several years. The nursing staff become an extension of the patient's family and the Nursing Unit Manager was a part of that family -- chose to be a part. Although the nurses still maintain that relationship, they express that the patients actually miss the involvement of the nurse manager in their care. The Service Managers (generally speaking), have little contact with the patients. And many staff wonder if that is a good way to run a patient unit. One nurse member related this to ships and their captains :

> all ships have to have a captain, I do believe it is best that the captain of the ship knows how the ship runs, in order to do it properly, because if the captain of the ship doesn't know how the ship runs, the ship will break down. Where it will work, is if the crew is good, but if the crew isn't good and the captain isn't good, that ship is sunk.

When asked to explain further, this nurse went on to say that we are in the business of patient care but if the manager doesn't take the time to know his "customers" -- how can they possibly think they know what is going on? Nurses don't feel it is a personality flaw in the individuals who are managers, they honestly believe that nurses understand patient care issues best: "like with our manager, we like him a lot, and he's very good, but he's not a nurse and it's very obvious." Because of this perception, nurses see their role as being even more vital to ensure holistic patient care.

Theme # 3 : Consultation and Collaboration

The one consistent message that was sent by all participants, was that since the implementation of the Service Manager position, there is a lot more consultation being done. These consultations are in the form of nurse-to-nurse consultation, nurse to interdisciplinary team member consultation, and nurse to Service Manager consultation. This is expressed as an extremely positive factor from the nursing staff's viewpoint. With regard to the nurse-to-nurse consultation, the Registered Nurses noted that "there is more collaborative decision making between the RNs

whereas before, you always went to the Nursing Unit Manager." The nursing staff identified that as nurses "we are learning to be more reliant on each other." They recognized the importance of supporting each other in order to have a good nursing team. There was a sense that "we have to, there is no other way, there is nobody out there that we can turn to." These nurse-to-nurse consultations were especially important in the instances where a practice concern is the issue. In the past, any concerns regarding the practice of a member of the nursing staff, were brought to the attention of the Nursing Unit Manager. These practice issues are now discussed within the nursing staff, with the Service Manager being brought in if the practice issue develops into a performance issue. The Service Managers are also beginning to consult with the nursing staff (particularly the Registered Nurses), regarding questions or concerns they might have regarding practice issues.

The increased consultation between the nursing staff and the other members of the interdisciplinary team was seen as a major advantage. In the past, the practice was to address any nursing-related issue to the Nursing Unit Manager, and the manager would then relate the issue to the nursing staff involved. There is a sense from the nursing staff, that there is more interaction between nursing and the other health professionals. One nurse described the benefit as: "I'm learning a lot more about the other disciplines and the other disciplines are learning a lot more about nursing." This increased collaboration with others outside of the nursing profession

will enhance their ability to articulate their role and increase their professional profile within the team.

For one particular Registered Nurse, the increased consultation between nursing allowed her "to mentor a lot more of my peers which is something that's very important to me."

Theme # 4: Education and Professional Development

Although this issue was relatively significant in Phase 1 of the study, the emphasis here was the recognition that, as staff nurses, they are accountable for their own learning needs. They did identify one challenge in doing that -- "having to have a lot more self-initiative and actually giving yourself the permission to go to sessions because you are no longer assigned to go by the Nursing Unit Manager." Many nurses state that their colleagues are not supportive of them attending sessions, "because they will have to take your patient assignment and resent you for it. So after awhile, you learn not to ask to go." They realize that this is an issue that they need to address if they are to remain competent and up-to-date.

One of the biggest changes they identified regarding this area is with the annual performance appraisal. Traditionally, the Nursing Unit Manager would complete the performance appraisal and identify the learning objectives for the individual nurse. Since the Service Manager position was implemented, the nursing staff are being requested to provide input into the performance appraisal and identify their own learning objectives.

With regard to the educational needs of the collective nursing staff, there were still some concerns that these needs are not being adequately addressed. One perception (from a nurse Service Manager) is that "nursing is floundering and continues to flounder because they can't see their way out." This view is consistent with the views expressed in Phase 1, in that the nurse managers tend to view things from a more global perspective, while the nursing staff focus more on the immediate issues and concerns. This may explain why there was such a difference in perspective. Staff nurses felt that they were adjusting well, whereas the Service Managers (nurses) saw major gaps that need to be addressed.

Phase 2: Interpretation

Phase 2 of the research study occurred approximately 8 months post-implementation of the Service Manager position. The results from the data collected indicated that the nursing professionals are continuing on their journey in a positive direction. The intensity of emotion expressed in Phase 1 greatly diminished. Although they had a tendency to disagree with the change to the Service Manager position, they could understand the rationale for it (common statements included; "I can see why they did it, but I still don't like it."). The comments were generally positive in nature, expressing more a sense of frustration than actual anger.

From a broader perspective, the difference in the prevalence of the themes was quite interesting. At this point in the study, the main focus of the nursing

professionals was the increased sense of accountability and involvement in decision making. As the major theme in this phase, this was a marked difference in focus and attitude from the first phase. The nursing staff clearly and consistently articulated that it is, not only their responsibility, but their obligation to be involved in more decision-making arenas. Although this was expressed in positive terms, there were negative aspects also described. The Registered Nurses, in particular, found the additional accountability welcome, yet challenging. These observations can be attributed to components of role theory. The role expansion that the RNs are experiencing is common within a reengineering environment. But that doesn't make the transition any easier. Chapter 2 made reference to various types of role stress that can occur in these types of situations (Bertrand, 1972). One example of role stress that is evident here is that of role ambiguity. The comment that "there is a lot of confusion regarding exactly who is accountable for what" is reflective of role ambiguity. The role sets are also being redefined as the roles evolve. The nursing staff find themselves involved in different activities that will require different skills (operating and budget planning, or chairing a family conference, for example). This can also be described in terms of role expansion, as the nursing staff assume roles that were once exclusive to the Nursing Unit Manager.

Of particular interest was the difference in perspectives between the nursing staff and Service Managers (nurses). The nursing staff held a more focused perspective (more unit based, specific to their needs), while the Service Managers tended to

view things from a more global perspective. What was interesting was to observe the Service Manager's sense of frustration that the nursing staff weren't capable of dealing with larger issues, couldn't see the big picture, and were still "apathetic."

It is my opinion, the response of the nursing staff was quite appropriate considering the historical background, not only of West Park Hospital, but of health care institutions in general. Their "world" consisted of the activities and patients on their specific unit. Traditionally, staff nurses have never been invited to participate in the conversations and decision making regarding global issues. This has traditionally been the arena for the nurse managers. Historically, West Park Hospital invested little resources into the professional development needs of the nursing staff. Clinical development occurred as required, but concentrated efforts to develop the "professional" did not begin to occur until 1990. If the nursing staff are viewed as being unable to see the big picture or be involved in major decisions, then the individuals or systems making that observation must ask "how did we contribute to the reality before us?" One cannot place blame on the nursing staff for continuing to demonstrate the desired behaviors required by a hierarchical structure that they have been a part of for several years. The old structure has been replaced with a revised one, patience must be key as the new desired behaviors for this structure are identified and communicated, with supports put in place to assist everyone in the transition.

An additional area to note was the change in orientation of the nursing staff with regard to their professional identify. During Phase 1, they were very concerned how this was going to effect "them" as nurses. The perception was that the Service Managers weren't going to be able to understand "nurses" and that would leave them "vulnerable." Within Phase 2 of the study, their focus had shifted to the issues of patient care. The perception that the Service Managers don't understand patient care as well as nurses do is now the common concern amongst the nursing staff. This indicates that a greater degree of critical reflection has occurred regarding the issues of the non-nurse manager. The nursing staff appear to have moved beyond the content and process reflection that was evident in the initial phase and gone to the premise reflection that is described as leading to a transformative learning experience (Cranton, 1994). The move beyond the "what is happening?" and "how will it effect me?", to "why is this important?" thinking indicates a raised consciousness to the real issue at hand.

Some changes in behavior have been identified but the major impact seen in this phase is the increased awareness of the importance of nursing in the overall patient care process.

Phase 3: Research Findings

Phase 3 of the study was conducted in December, 1995, 14 months post-implementation of the Service Manager position. The total number of participants had decreased from previous phases of data collection, but the participants

remained reflective of the collective nursing group (see Table 1). As in the previous phases of data analysis and interpretation, the themes are presented in terms of their prevalence in the data collected from the focus groups.

Theme # 1: Professional Accountability

The theme of professional accountability was again at the forefront when nurses were questioned about their perceptions regarding the Service Manager position. Many of the observations and perceptions that were expressed in Phase 2 were repeated again in Phase 3, but there were also some different issues emerged.

Consistently, nursing staff will express a heightened recognition of the increased accountability and authority that they have regarding patient care and nursing-specific issues ("we know that clinical issues with regards to patient care are owned 100% by the nursing staff now"). Generally, they enjoy the ability to independently make decisions and be more involved in the operational side of managing the unit. The Registered Nurses, in particular "find that we are being pulled into a lot more of the operational sides of things and that is good, because now we can see what everything is all about."

Although this experience was generally seen to be a positive one, one Registered Nurse observed that the more experienced RNs might be better equipped to handle the changing role:

> the impact on the older RNs is not that much, but I can see that for some of the younger RNs that this is a bit intimidating and that's because they don't have the

> 20 -30 years of experience behind them. By having the 20 -30 years behind you -- you can cope with anything! I think that this would be very scary for someone who didn't have a lot of self-confidence.

There was a greater sense of awareness of how dependent they allowed themselves to be on the Nursing Unit Manager for any decision making. One nurse stated :

> I almost wish that we didn't have a Service Manager that was a nurse, because then it would force us to address those issues on our own, instead of us keeping the bad habit of allowing the manager to deal with those issues for us.

Another nurse, who has a non-nurse Service Manager described the same issue, but from a different perspective:

> As a result of the Service Manager position, we have become more independent and more self-sufficient -- and we always were that way, but you know that if you can pass the buck to someone else-- you will. If you can't pass the buck anymore, then you have to cope with it yourself.

As the nursing staff assume more accountability for patient care issues, they have identified that their role as nurses has changed and continues to change. Within this larger context, they have also identified how their individual roles (as Registered nurses and Registered Practical Nurses) are changing. As a collective group of nurse, they are experiencing a lot of frustration because of the role changes -- "nobody seems to know what the role is anymore." This lack of role clarity has created tension between the RNs and RPNs, because the job descriptions are no

longer reflective of what is required. The RNs, in particular feel that they are in "new territory without a current map."

There is a difference in how the RNs and RPNs perceive this role change. The RNs identified having a lot more responsibility and with that, a lot more pressure. Some of the additional challenges are welcome, but some RNs feel that "they are pushing the RN to do more work away from the bedside and I think that they are kicking us out of a job by doing that." Many RNs also expressed that they felt that they were not adequately prepared for the additional responsibilities.

With regard to authority for decision making, the RNs noted that there are gaps in the present system: "they tell me that I have this power, but sometimes I don't see it." RNs told of situations when they had identified a problem, determined the best solution, but still had to go to an external source for the final OK and that caused a lot of frustration.

The RPNs feel that they have been able to expand their role within this environment. With the RNs being involved in a lot of the operational activities, the RPNs are picking up a lot more of the clinical side of things and being more accountable for their own scope of practice. As the RNs identified that they had a tendency to rely on the Nursing Unit Managers, the RPNs noted that they also deferred issues to the RNs. One RPN was quite proud of this change stating:

> We as RPNs are acting more independently, within our own scope of practice. Instead of waiting for the RN to assign us the tasks, we look to see what has to be done. I don't find that scary as an RPN, I find that challenging.

When asked the question: As a result of the Service Manager position, do you feel that you have changed the way you approach nursing as a profession?, many staff were quick to respond. Some felt "not really because we are doing what we were supposed to be doing all along." But the majority of nurses felt that it has made a positive impact on them as professionals. One nurse described her experience as :

> "Yes, it has changed the way that I practice. Before I would never suggest any changes or make recommendations, or take any initiative. But lately I've found that I've gotten more mouthy because they have pushed me to be that way. I'm more outspoken and willing to speak up and say things and I'm not scared anymore. I'm not afraid to say things if I feel that I am right. If I think that I am right, then watch out -- and I would never do that before. Now I get in there and do things as opposed to taking a back seat.

Another nurse describes how this restructuring has affected her self-confidence by explaining how she found herself marketing the services of West Park Hospital to a visitor and that she felt really good about doing that -- "so I felt really good because at the end he was really, really grateful. And I was glad to have the chance to do that for him."

Theme # 2: Consultation and Collaboration

The thoughts and observations regarding the importance of consulting with nursing colleagues is still very much evident in this phase of the study. Many nurses make reference that they are pulling together more and that has helped to build up a greater sense of trust. That sense of trust was seen as vital to having a good functioning team -- "If you don't have a sense of trust -- you don't have a team." One negative side was noted in that many nurses felt that a lot of things were "falling through the cracks" because there was no one team leader. This was an issue that many areas were beginning to address -- how to keep the unit running without resorting back to the traditional "one-person" accountability systems.

The major advantage that was seen was in the enhanced relationship between nursing and the interdisciplinary team. There were several comments reflecting the importance of interdisciplinary team members "having to deal with us directly instead of going to the manager." They really felt that increased their profile in the team and within the organization. One nurse described her thoughts as "it's been positive for nursing, it has helped to bring the respect back to nursing because they are now dealing with us."

Shared Governance was also identified as a means for them to collaborate with other nurses in the organization. There was a collective sense that to have Shared Governance structure in place before the implementation of the Service Manager

position has helped with the transition ("I think that if we didn't have Shared Governance, we would really be in big trouble").

Theme # 3: Professional Identity

The nursing staffs' perceptions regarding how they view themselves as professionals remained fairly consistent as in the previous phases of the study. The nursing staff strongly believe that a non-nurse Service Manager doesn't have the same appreciation for patient care that a nurse does. One nurse described her view in the following way:

> OK, here is how I see it. Nursing is the biggest part of the unit right? Shall I say the most important part? - well it is the most important part! And I find that these managers cannot relate to patient care issues. It is very time-consuming to have to explain all these things to them when you know they won't understand it anyway. They just don't get it! Is there a difference between these managers and the NUMs (Nursing Unit Managers)? - Oh yeah- big time! The NUMs were still very much involved on the unit, they knew all the patients by name. These guys are too businesslike, where nurses are more human."

Another nurse also tells of a situation where it became quite clear to her that the managers were different:

> Once I went to tell the Service Manager that we had a couple of really sick patients and her immediate response was "Oh my God -- the budget!" From

> that point on I decided that I would never bother to go to the Service Manager with another patient related issue again -- and I find that a little sad.

These situations clearly depict the nursing staffs' value of the caring component to the service they provide.

In Phase 2, the participants described their relationship with their clients, as being members of an extended family. They identified this as being a special relationship between the nurse and patient -- something that they valued. One rather alarming change in this area was articulated by the participants in one focus group. These participants indicated that as a result of having other disciplines on the unit, that they are being questioned about their relationships and some nursing behavior by the non-nursing disciplines. The nursing staff again referred to the notion that nurses have a special relationship and others don't have the same appreciation for patients that they do. The following describes the situation:

> I think that we now have a tendency to be less friendly with the patients -- we have to watch everything that we say. Now that we have people on the units all the time that aren't nurses, the other disciplines don't have the appreciation for what they are hearing. This has taken something away from our relationships with our clients. Because we feel guarded. I don't joke as much as I used to -- I feel self-conscious as if I'm looking over my shoulder. If someone doesn't understand what it is that you are doing, there's always harm to yourself. They look at it through their eyes instead of the eyes of a nurse. I've known some of

these patients for 15 years, when joking with them and them joking with you -- some hear that and don't appreciate the relationship. They just think that what they are hearing is something unprofessional.

As the researcher, I found these comments very interesting. This issue was only brought up in one focus group, but the group was very diverse (several units represented) and all participants agreed with the comments. Considering the high value nurses place on their relationships with their client, this issue needs to be further investigated to determine what the extent of this perception is, and what action, if any, needs to be taken.

Phase 3: Interpretation

Phase 3 was conducted 14 months after the implementation of the Service Manager position. It remains clear that these professionals are still on a journey, but that journey has provided some personal and professional rewards. There are also new challenges being faced that did not present themselves in the earlier phases of the study. It is my opinion that the data presented here are indicative of the professional growth of the nursing staff. They have moved beyond an introspective view of the situation and are now able to identify gaps in the system that act as barriers to them assuming their new role to the best of their ability. This is not to say that they fully embrace the idea of a non-nurse Service Manager, but they have been able to articulate their role and areas for legitimate authority and accountability.

The biggest challenge appears to be in the area of role development and role clarity.

Both the RNs and RPNs are experiencing expanding roles and with that comes the issue of role clarity. There is a sense that both parties are becoming more comfortable with the revised roles, but need more time to adapt. There is no sense that they are actively resisting the change, but have identified learning needs associated with these new role sets. There still exists role frustration and role ambiguity, particularly from the RNs.

Some barriers that were identified included the gaps in the present system that does not support what are expressed as the desired behaviors within the new structure. Independent decision making is an expoused theory, but the system does not yet fully support that happening. The RNs have identified this as an area of extreme frustration, comments such as " they tell me I have this power, but I can't seem to use it," are reflective of traditional organizational hierarchies still in place. The staff have identified areas where supports need to be put in place -- it would be of interest to see how active a role they play in ensuring that those supports are implemented.

In terms of transformative learning, the data indicated that the implementation of a non-nurse Service Manager position has truly been a transformational experience for these nursing professionals. The data in this phase described the changes in

behavior, on a personal and professional level, that has occurred in the nursing staff at West Park Hospital.

Summary of Chapter

The analysis of the collective data reveals that the nursing staff at West Park Hospital experienced a transformative learning experience with the implementation of the Service Manager position. There was a definite shift in the focus of the data and themes that were generated from the three phases of data collection that indicated critical reflection and changes in behavior as a result of this new position.

In Phase 1, the primary concern that was expressed by the nursing staff was how this new position was going to affect them. Many of the statements consisted of : "what will this do to us?"; "who will understand us?"; and "will they understand what we do?" The removal of the Nursing Unit Manager and the implementation of the Service Manager position can definitely be described as the trigger event that facilitated a great amount of individual and collective reflection and dialogue regarding the professional identity and role of nursing within the facility. Many nursing staff viewed this as an extremely negative and threatening experience, leaving them "vulnerable" to decisions made by those outside their discipline. There was some concern expressed in terms of how future learning and professional needs were going to be met if "they don't know what we need." Very few nursing staff viewed this as an positive opportunity to further expand the role of nursing.

In Phase 2 there was an increased sense of awareness for a need to change in light of the new reporting structures and accountabilities. Issues of professional accountability were at the forefront of discussion at this point in the study. Many well-established assumptions were being actively questioned as the nursing staff realized that they must assume legitimate ownership of many of the issues that had traditionally been within the domain of the Nursing Unit Manager. At this phase of the study, many nursing staff were able to articulate some changes in behavior that were already evident in themselves and their colleagues. Some of these included: increased collaboration, dealing with practice issues themselves, and increased independent decision making with regard to patient care issues. Although there was an definite shift in the perspective regarding the Service Manager position (they could understand the rationale behind the development of the position), the nursing staff continued to state that they felt that nurses were still better suited to manage patient care areas due to their more humanistic approach to care.

Phase 3 indicated a shift to a more systems perspective on the Service Manager position as it related to them as nursing professionals. It is within this phase of the study that the nursing staff began to explicitly articulate the "why" behind their belief that nurses are better suited to manage patient care areas. The nursing staff expressed concern regarding how they perceived this position impacting patient care. This was a dramatic shift from the focus that was evident in Phase 1 of the study. This ability to articulate the added value that nursing brings to patient care

was not evident in any of the previous phases of data collection. Nor was this evident prior to the implementation of the Service Manager position. There was an awareness that there were gaps in the present structure that were acting as barriers to them fulfilling their new roles. Comments such as "they tell me I have this power, but I don't see it" is an example of one such gap. There was also a great amount of discussion regarding the role confusion being experienced by the Registered Nurses and the Registered Practical Nurses. The job descriptions were no longer seen to be reflective of what was being required of the nursing staff in the current reality.

It is clear that the nursing staff have revised some of their assumptions regarding their professional identity and accountability. In terms of the non-nurse manager position, they continue to believe that nurses are best suited to manage patient care areas, but the shift that has occurred is that they can now explicitly and objectively articulate the reasons behind this belief and are more comfortable with the role of leading themselves, instead of being led by another.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND IMPLICATIONS

Summary

The objective of this study was to determine the perceptions of nursing staff regarding a generic Service Manager position. Of particular interest were the nursing staffs' perceptions regarding their own professional identity and accountability within this new reporting structure.

The review of literature presented in Chapter 2 included: historical perspectives on organizational structures, current management theories, role theory and transformative learning theory.

Chapter 3 described the research paradigm and methodology that was determined best suited to meet the objectives of the study. A longitudinal qualitative design was utilized to determine the initial perceptions and if those perceptions changed over a period of time. Data were collected through the use of focus groups that were conducted in three phases over a 14 month period of time. The data collected from each phase of the study were analyzed and interpreted independently. Chapter 4 concluded with the collective results interpreted and related to the relevant literature presented in Chapter 2.

Conclusions

The purpose of this study was to determine how professional nurses perceived a generic Service Manager position as it related to their professional identity. Of particular interest were the nurses' perceptions regarding their own professional accountability and autonomy in light of this new reporting structure.

The notion that patient care areas must be managed by nurses has traditionally been viewed as somewhat of a "sacred cow." Yet, when nurses are asked to articulate the basis for this argument, the individual cannot explicitly explain something that appears to be implicit to the collective group. The results of the study are of interest to nurses, regardless of the organizational structure they may be in.

The analysis and interpretation of data presented in Chapter 4 clearly display the perceptions of the nursing staff regarding the non-nurse Service Manager position. The implementation of the Service Manager position can be described as a trigger event that facilitated individual and collective reflection regarding traditional roles and accountabilities within nursing. As presented in chapter 4, the nursing staff initially reacted with great emotion and reservation to the implementation of the Service Manager position. This reaction and perspective transformed gradually over the fourteen month duration of the study. There was evidence of critical reflection, challenging and revision of assumptions, resulting in demonstrated and

reported change in behaviors. The perspective changed from one of personal threat and feelings of vulnerability to that of increased professional identity and professional self-worth, including a systems perspective on the role of nursing.

While transformative learning theory was used as the main theoretical framework to examine how the nursing staff responded to this change, the review of the literature relevant to the historical perspective on management theory and role theory provided the background information as to why the implementation of a generic Service Manager position might be perceived as a threat to the nursing professionals. Nursing has historically provided service based on the concepts of the division of labor and the specialization of skills. Nursing further specialized itself by creating an internal hierarchy of nurse managers and nurse clinicians. Nurse managers managed the business of health care and the nurse clinicians provided the direct care. This was described as having created a highly professionalized nursing management staff and a highly vocationalized nursing clinical nursing staff (Porter-O'Grady, 1992). The implications of this are evident within the data generated in Phase 1 of the study. With the Nursing Unit Manager position eliminated, the nursing staff felt vulnerable due to the loss of their advocate and spokesperson. The nursing staff found themselves unable to explicitly articulate their role and were fearful that the non-nurse manager would not appreciate the complexity of the profession.

In terms of role theory, that notion that nurses must manage patient care areas can be described in terms of mores, norms, and status. The role of nurse as manger had never been challenged before, and as a result of this, all roles were now being critically reviewed and revised based on the work that needed to be done. This was seen clearly in the role expansion experienced by the Registered Nurses. Along with this role expansion came role stresses due to lack of clarity and consistency.

Implications for Practice

The results of this study have implications for many areas within the nursing profession specifically, and the health care industry in general. The majority of literature regarding program management, refers to the threats of the loss of professional identity of distinct professional groups. Nursing is often seen as a major barrier to the implementation of such a model due to this perceived threat.

With regard to the nursing profession, an area where this study can be of value is within the nursing academic community as they design nursing curriculum. The results of the study clearly indicate that nurses in general cannot explicitly articulate their role in terms of the overall health care system. As the health care industry continues to go through its own transformational process, nurses must be able to objectively articulate the essence of what nursing is to those outside the nursing profession.

of them. The academic community may need to reexamine the curriculum to incorporate such areas as organizational learning, management theory, delegation and negotiation skills as basic elements within all nursing programs.

There are also implications for practice within health care facilities undertaking reengineering projects. The data generated from this study can be utilized when considering a similar restructuring. The data describe the concerns, learning needs and system considerations to support revised roles, that should be considered when preparing staff for the implementation of a program management model. If the issues of role clarity, skill gaps, and professional accountability are addressed proactively, then the transition to a new organizational structure and philosophy can be more easily facilitated.

Implications for Theory

The findings of this study have confirmed the application of transformative learning theory as the theoretical basis for this study. The data generated from the three separate phases clearly outline the transformative learning process as described by Mezirow (Mezirow, 1991). The nursing staff were faced with a trigger event that truly forced many assumptions to a level for review and validation. As a result, there is ample evidence of changes in behavior as a result of that process. The data also clearly reinforces the importance of support for the participants during a transformative learning experience due to the anxiety and

that process. The data also clearly reinforces the importance of support for the participants during a transformative learning experience due to the anxiety and confusion that can occur as new perspectives and associated behaviors are incorporated.

The literature on role theory and the historical perspective of management theory also reinforced the reasoning as to why program management and generic manager positions can be viewed as such a disorienting dilemma. The literature on program management describes both threats and opportunities to the nursing profession. It is clear that the nursing professionals at West Park Hospital experienced the threatening aspect in the initial phases, but embraced the opportunities that are available and the personal and professional benefits that result from those opportunities. There is no question that the nursing professionals at West Park Hospital feel that their professional identify has been strengthened as a result of the activities associated with the implementation of the Service Manager position.

Implications for Further Research

When considering the data relating to the nursing staffs' perception of the Service Manager position as it related to their professional identity, two additional areas for further consideration become apparent:

1. Impact on patient outcomes : The nursing staff identified that, as a result of the implementation of the Service Manager position and the associated

awareness of professional accountability issues. A relevant research question would be to determine: Will these changes in the nursing staff have a direct impact on patient care outcomes?

2. What are the core competencies required for nursing professionals in today's health care environment? The types of activities that nurses are being requested to participate in are extremely different than they were 5 years ago. The nursing staff identified that the job descriptions are no longer reflective of the activities they are involved in. In order to address issues of role ambiguity and role stress, an analysis of competencies required for nurses would be of value.

Recommendations

1. Although the nursing staff generally perceived this experience to be a positive one, there were many gaps in the present systems and processes that need to be addressed. Areas such as authority for decision making, reviewing role descriptions, and clearly identifying areas of professional accountability should be addressed with the appropriate management team.
2. there should be increased educational support for the nursing staff as they continue to assume new roles and tasks that require new skill sets. This will be particularly important for the Registered Nurses as their role expands in areas that were traditionally the domain of the nurse manager.

particularly important for the Registered Nurses as their role expands in areas that were traditionally the domain of the nurse manager.

3. Although this study was designed to examine the perceptions of the nursing staff within a specific facility, the applications of this study to other facilities should not be overlooked. The example of a "generic manager" could be used as a hypothetical scenario to generate dialogue and determine the underlying assumptions staff have regarding roles, issues of accountability, and professional practice.

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Appendix A : Participant Consent Form

Consent to Participate in Research Study:

"Nursing Staffs' Perception of a Generic Service Manager Position"

I,_____ willingly agree to participate in focus groups designed to collect data regarding nursing staffs' perceptions of the Service Manager position. I understand that the focus groups will be audio-taped as a means of recording and storing data, and the confidentiality of all participants will be ensured by the researcher. I also understand that the participation in these focus groups is voluntary and that I have the right to withdraw at any time without penalty. Results of the focus groups will be presented as collective responses and references will be made only to nursing status (Registered Nurse vs. Registered Practical Nurse), if applicable.

_____ _____

Signature of Participant Date

I would like to be informed of the results of the research study upon its completion.

Yes_____ No_____

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